Defence Update

Quarterly Magazine of the MDA National Group

MDA National

Dental Injury During Anaesthesia

Avoiding a Clot on Your Record

The Elective Essay Competition and the winners are...

1925-2005

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YEARS OF SERVICE

September 2005

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State Regulations for S8 and Other Drugs of Addiction

Australian States' Health Departments have in place regulations for controlled use of narcotics, stimulants and other drugs of noted addictive potential. These regulations restrict prescribing to a set number of days (usually 60) before specific consent from the Health Department is required for each individual patient. Consent is then granted for up to 12 months of repeat prescriptions. Intrinsic to this consent process is an obligation upon the practitioner to provide diagnosis, staging of disease if appropriate and prognosis if possible. If these details are not provided then consent will not be provided. Prescribing without consent will lead to action against the practitioner.

Concerns have been raised about patient consent to provide this information to a government department.

- Does the practitioner require the informed consent of the patient to do so?
- Would the practitioner be in breach of the National Privacy Principles (NPPs) in complying with this requirement?

It is always good practice to obtain informed patient consent.

However, in this instance the NPPs provide that where adherence to a government regulation is required, then an exemption to NPPs consent is mandated.

Nonetheless, it remains good practice to keep your patient fully informed about the means required to meet their medication needs.

Dr Reg Bullen
Medico-Legal Claims Manager

From the President

The Medical Indemnity Industry Association of Australia (MIIAA) is the peak industry body for Medical Indemnity Insurers (MIIs). MDA National shares data with four other insurers and the resulting information applies to more than 75% of doctors in Australia. The figures from the 2004 report make for some interesting reading (http://www.miiaa.com.au/reports.php).

Thanks to tort reform and responsible management, premiums for doctors are decreasing for the first time in a decade. Since 1995 the average premium rise across the country has been 245%. In the 12 months to July 2004 they reduced on average 4%. Of course the premium is capped at 7.5% of gross billings anyway for high premium payers, but the issue of affordability should be neutralized now for all but a few doctors in special circumstances.

Claims numbers are decreasing (down 4%) but their costs are still increasing (average 3% over inflation per annum). This reinforces the need to retain the tort reforms that were put in place in response to high costs and rates of litigation. There are strong lobbyists within the plaintiff lawyer groups who have an interest in returning to the days of more open access to the courts for minor and frivolous claims. The needs of patients are not best served by spending more money in the legal system.

Doctors are demonstrating that they can be accountable without necessarily having to fund an enormously expensive legal system. MDA National supports "open disclosure" by doctors to their patients in a proven non-legalistic model. Open Disclosure has already been given, in part, legal sanction by the statutory protection enacted in all states that enables doctors to apologise to patients such that the apology cannot be construed as an admission of liability. That is a useful legal initiative – protecting the doctor and patient from the legal system, not drawing them further into it. Risk management, improved communication and addressing system issues are the credible proven ways to advance safe patient care. This will also hopefully reduce legal costs and claims as a by product.

Finally the report is encouraging in that it demonstrates that the MIIs are collecting enough money to cover all predicted claims. This means a sustainable industry that will still be around to meet the costs of future claims.

The MIIAA has also made a submission to the Productivity Commission on the effects of medical indemnity issues on the medical workforce (http://www.pc.gov.au/study/healthworkforce/subs/sub062.pdf). One of the areas of interest is that of Overseas Trained Doctors (OTDs), an issue which has unfortunately been tainted with controversy after the actions of a few individuals. It should be remembered that OTDs perform many vital functions in our health system and that many of us have been OTDs in other countries during our training. However it is very important that qualifications are properly verified by Medical Boards. Insurers will use risk management tools such as restricting types of practice or requiring supervision but this can be difficult especially in remote areas. For the safety of patients the standards expected of OTDs should not be unreasonable but neither should they be materially less than those of Australian trained medical practitioners.

MDA National has recently been involved in providing legal advice about schemes where doctors are asked by the State Government Health Departments to enter into cost shifting arrangements, whereby public patients are treated and Medicare is charged in the doctors' names. Members are advised not to enter into these arrangements unless appropriate protection from action by the Federal authorities is in place. At the least this would include a direction by the Federal Health Minister under s.19(c) of the Health Insurance Act 1973 (Cth) (http://www.austlii.edu.au/au/legis/cth/consol_act/hia1973164/s19c.html) that Medicare benefits are payable in respect of the services. Contact MDA National or your state AMA if you are unsure of the status of any cost shifting arrangement that you are asked to participate in. Members have been caught up in disputes and investigations after such schemes have been implemented in the past.

We have all made it through the renewal time of the year now. This process puts strain on our staff and involves a significant workload for our members in digesting the information that goes out. We have managed to increase our membership numbers again and it is a tribute to the management and staff that there have been very few and minor problems with getting all of our members insured again. It is a tribute to our members that you have all coped with the paperwork that attends the offering of a complex policy with the amount of government regulation that we now face.

Finally, there are some excellent articles in this issue of *Defence Update*. The rise of Bariatric Medicine is of particular interest to those of us interested in emerging risks. Emerging risks are those clinical and legal risks that are not part of the established medical landscape; the risk of what's new. They are things that evolve during our professional life that can catch us by surprise unless we remain up to date and are cautious in our approach to new diseases, investigations, treatments and procedures. The industry is developing an education module to specifically address how doctors can identify what their emerging risks are and what an appropriate way of managing them might be. Happily we don't have to face new things alone and the resources offered by the Colleges and other groupings of our peers will be very useful in detecting and managing emerging risks. Bariatric medicine is in a growth phase and the risk management tips contained in this issue will hopefully help members manage the issues associated with its increase in popularity.

Dr Andrew Miller

President

Teleconference Discussion Forum

MDA National held its first teleconference discussion forum in May, bringing together clinicians from WA, Qld, NSW and ACT to discuss prevention of surgical site infections. Participants in the teleconference were generally positive and a useful discussion ensued. Some positive comments were that it was good to hear the views and experiences of others; it was an informal, interactive session which brought doctors together Australia-wide. Topics for future discussion forums are DVT prophylaxis, medication safety in General Practice and medico-legal issues.

Preventing Surgical Site Infections

During the May teleconference discussion forum, a range of strategies for preventing surgical site infections were discussed. There was consensus in the group on the following prevention strategies:

- Patient selection – where patients are at high risk of infection, extra precautions should be taken and in some cases surgery postponed and the patient encouraged to lose weight or stop smoking. Investigate the possibility of latent diabetes where indicated.
- Hospital selection – ensure that the level of hospital is appropriate to the surgical risk of the patient and that high risk patients are supervised post-operatively by the surgeon.
- Consent and warnings – where patients have high risk of infection such as those with morbid obesity (BMI > 40 kg/m2, or BMI > 35 kg/m2 with obesity-related co-morbidities) then more attention should be paid to warnings and discussion of risk and alternative options (including the 'do nothing' option).
- Use basic elements of good surgical technique including:
  - Good haemostasis.
  - Adequate drainage.
  - Recognition and management of technical errors.
  - Minimisation of dead space.
- Prophylactic antibiotics, selection and timing of administration – it is crucial that antibiotics are given on induction of anaesthesia (1 hour prior to induction for Vancomycin). Have processes in place so that appropriate antibiotic prophylaxis is given such as:
  - A wall chart in the operating room listing antibiotic choice and dose.
  - Incorporate antibiotic prophylaxis check into surgical team time out prior to commencement of operation.
  - Check allergic status and plan alternate antibiotic regime pre-operatively where indicated.
- Skin preparation – while there is 1A evidence for clipping rather than shaving there are practical difficulties associated with this (cost of disposable clipper head, difficulty getting good clearance without nicking skin and the time it takes to clip).
  - If shaving rather than clipping this should be done at the time of surgery.
  - Use Chlorhexidine skin prep instead of iodine based preparations.
  - Check history of skin infections.
  - Have patients shower with antiseptic soap pre-operatively.
  - Prevent intraoperative hypothermia.
- Diabetics - monitor glucose level and maintain levels in control. Test obese or other high risk patients for latent diabetes.
- Use of prostheses - avoid mesh in high risk patients where possible.
- Drains - use closed suction drains. Where drains are left insitu after discharge they should be closely monitored by the surgeon.
- Follow-up after discharge by surgical team - there was general agreement that in all cases the senior surgeon should take responsibility for the post-operative management of the patient, while in hospital and after discharge. In very high risk patients there should be close supervision of surgical trainees and direct contact with the patient.

There were differing views on the acceptability of delegating responsibility for post-op management to GPs or other clinicians. It was acknowledged that there is difficulty and often no alternative for some rural surgeons where post-operative management was provided by GPs to minimise patients' travel requirements. In this case clear communication with the GP on indications for review by the surgeon is critical to manage risk. The discussion forum also identified that funding arrangements can discourage early post-operative follow-up, preventing early identification and treatment.

For further information on prevention of SSIs contact the Risk Management Department at riskmanagement@mdanational.com.au or 1800 011 255.

Louise Kershaw
Risk Manager

Avoiding a Clot on Your Record

Case Study 1– *Caley v Northern Regional Health Board*

The claimant's wife had a swollen foot within days of the birth of her third child. No investigation of the cause of the swelling was carried out and two weeks later she died of a pulmonary embolism. It was alleged that no advice was given to her regarding follow up if the swelling in her foot persisted and that a venogram should have been ordered.

Case Study 2

Ms K, a 31 year old mother of 2, ruptured her achilles tendon playing hockey while just 3 months post partum. She had it surgically repaired and 11 days later died of a pulmonary embolism. Although her surgeon had ordered Low Molecular Weight Heparin (LMWH) at the time of surgery this had not been administered while she was in the hospital.

Deep Venous Thrombosis (DVT) is a well recognised complication of surgery and hospitalisation and has gained increasing notice with the identification of Venous Thromboembolism (VTE) as a major risk of long haul flights. It has been identified that DVT (including sub-clinical thromboses) occur in up to 50% of hospitalised patients. The New Zealand Air Travellers Thrombosis study puts the incidence of VTE where travel time is at least 10 hours at 1%[1]. Thromboembolism is also the most common cause of direct maternal mortality accounting for 1 in 6 deaths[2]. The long term sequelae of DVT, chronic venous insufficiency and ulceration, can significantly impact a patient's quality of life.

Studies have shown that many thromboses are preventable using a combination of preventative measures such as LMWH, anti-embolism stockings, calf compression devices and exercise. Routine thromboprophylaxis has been a central part of good surgical care now for some years. However, there is solid evidence that while both surgical and medical teams may have a protocol for DVT prophylaxis a significant number of patients don't get the appropriate treatment. A recent study in three Brisbane hospitals showed that only 30% of highly eligible Chronic Heart Failure patients received appropriate DVT prophylaxis. With the implementation of clinical decision support, education and performance feedback this was increased to 73%[3].

The Australian and New Zealand Working Party on the Management and Prevention of Venous Thromboembolism have produced regularly updated Best Practice Guidelines for VTE prevention. In recognition that this is a key issue for patient safety and quality of care, MDA National is distributing copies of the Guidelines to all surgical members. If you are not a surgeon and would like a copy of the Venous Thromboembolism prevention guidelines please email riskmanagement@mdanational.com.au and a copy will be posted to you.

Travel Related VTE

The guidelines also provide useful advice on VTE prophylaxis for travel related DVT. For low risk patients they advise adequate hydration; exercise before, during and after travel; massaging and exercising calf muscles when seated and avoiding sedatives and excess alcohol. For high risk patients LMWH and properly fitted Graded Compression Stockings (20-25 mm Hg) are suggested[4]. The guidelines suggest that use of aspirin is not appropriate as it may have a weak protective benefit at best which does not weigh favourably against the increased risk of bleeding in some people. GPs who are unsure of an appropriate regime where patients have multiple complex medical problems, should seek advice from an appropriate specialist if they are at all concerned.

Louise Kershaw

Risk Manager

1. Hughes RJ et al 2003 *Frequency of venous thromboembolism in low to moderate risk long distance air travellers: the New Zealand Air Traveller's Thrombosis (NZATT) study* The Lancet 362; pp2039-44
2. *Clinical Practice Review* Newsletter 2001 July Maternal mortality and obstetric medicine.
3. Scott I A et al 2004 *Achieving better in-hospital and after-hospital care of patients with acute cardiac disease* MJA 180 ppS83-88
4. *Prevention of Venous thromboembolism. Best Practice Guidelines for Australia and New Zealand* 3rd ed 2005 HemiAustralia ISBN 0 9578909 2 3

Warfarin Therapy and Dental Extraction

Dr Doolittle received a telephone call from Mr Pullem, a local dentist, wanting to temporarily stop Miss Redgums' Warfarin prior to extracting one upper tooth.

Dr Doolittle demurred whilst she considered the options. Miss Redgums was on Warfarin for an ongoing problem (protein S deficiency). Her INR was 2.8 (2.6 to 2.9 range in the last 4 months). She consulted various E-journals and made her decision (like most GPs, her library was too aged to be current).

Discussion

This is a common occurrence even in this age of fluoridated water. Extractions are needed as are other dental procedures which may result in bleeding. Local measures are usually the only need which is found at such procedures. A web site which Dr Doolittle found helpful was www.warfarinfo.com/dentalprocedures.

In the letter below (reproduced with permission from *Medical Journal of Australia*, 2005; 182: 366-368), Professor Max Kamien has addressed an important and common problem for GPs (and also for physicians, pathologists and haematologists).

Dr Reg Bullen

Medico-Legal Claims Manager

TO THE EDITOR: a middle-aged woman with atrial fibrillation had her warfarin therapy stopped for 2 days before dental extraction. She had a catastrophic stroke and is now a plaintiff. I was asked if her medical management accorded with common practice.

At the October 2004 Annual Conference of the Royal Australian College of General Practitioners, I conducted a straw poll of 20 experienced GPs, of whom 18 said they would stop warfarin for between 2 and 4 days before a dental extraction. Some of these GPs regarded a dental extraction as elective surgery and pointed me to authoritative (but slightly ambiguous) sources to back up their views.[1,2] However, a review of the medial and dental literature show that this is an example of common practice lagging behind clinical evidence.

The first controlled trial of dental extraction in patients on warfarin therapy was conducted in 1983.[3] It showed that it was not necessary to cease warfarin prophylaxis for patients whose international normalised ratio (INR) was within the normal therapeutic range. Since then, two major literature reviews have confirmed these conclusions.[4,5] A recent Australian review on warfarin reversal expresses a similar point of view.[6] The incidence of a serious embolic complication from stopping therapy with warfarin is 1% and this is three times more likely to occur than bleeding complications in patients whose warfarin therapy was continued[4]. Furthermore, a stroke is a catastrophic event, while a bleeding tooth socket is simply messy and usually easily controlled.

An authoritative review and position statement on warfarin therapy and dental procedures from the Australasian Society of Thrombosis and Haemostatis may be the catalyst required to align common practice with clinical evidence.

Professor Max Kamien

Emeritus Professor of General Practice, University of Western Australia

In reply to Professor Kamien's letter, Professor Hatem H Salem on behalf of the Warfarin Reversal Consensus Group stated that:

"Kamien's comments are important and illustrate the difficulties in changing entrenched practices. We hope that our recommendations will go some way to improving the way we manage patients on warfarin therapy who are about to undergo surgery."

1. *Australian Medicines Handbook*. Adelaide: Hyde Park Press, 2004: 310
2. Hankey GJ. *Non-valvular atrial fibrillation and stroke prevention*. National Blood Pressure Advisory Committee of the National Heart Foundation. Med J Aust 2001; 174: 234-239
3. Bailey BM, Fordyce AM. *Complications of dental extraction in patients receiving warfarin anti-coagulant therapy*. A controlled trial. Br Dent J 1983; 155: 308-310
4. Wahl MJ. *Myths of dental surgery in patients receiving anticoagulant therapy* [review]. J Am Dent Assoc 2000; 131: 77-81
5. Carter G, Goss AN, Lloyd J, Tocchetti R. *Current concepts in the management of dental extractions for patients taking warfarin*. Aust Dent J 2003; 48: 89-96
6. Baker RI, Coughlin PB, Gallus AS, et al. *Warfarin reversal: consensus guidelines on behalf of the Australasian Society of Thrombosis and Haemostasis*. Med J Aust 2004; 181: 492-497

Whose Right to Confidentiality?

Royal Women's Hospital v Medical Practitioners Board (2005)

On 29 June 2005, amid a storm of controversy, Justice Gillard of the Supreme Court of Victoria ruled that the Royal Women's Hospital had to produce to the Medical Board records relating to the termination of a 32 week old foetus. The ruling was strenuously opposed by the hospital in the interests of the mother whose privacy and confidentiality were considered to be paramount. The debate that arose provides an opportunity to review the strength and basis of a claim that medical records ought to remain confidential.

In May 2001, Victorian Senator Julian McGauran, an anti-abortion campaigner, made a complaint to the Medical Practitioners Board of Victoria about the conduct of doctors involved with the termination of a 32 week old foetus after the mother (identified as Mrs X) became hysterical and suicidal upon learning that her foetus might have dwarfism. The Board's investigation was hampered by Mrs X's refusal to allow access to her records. The Board eventually obtained a search warrant and obtained a copy of Mrs X's records. This application was shortly followed by a counter application by the hospital that the records be returned. The hospital's application was refused so they appealed to the Supreme Court of Victoria. The thrust of the hospital's grounds for appeal focused to a large extent on the sanctity of doctor/patient confidentiality. The law clearly recognises that the relationship between doctor and patient is a confidential one. However, the sanctity of the confidential relationship will not prevent a doctor from divulging documents or information when compelled to do so by law.

Not one of the hospital's arguments were accepted by Justice Gillard who found that:

- the legal privilege granted by the Evidence Act was limited to certain types of civil matters (this being a disciplinary matter);
- that the Health Services Act did not prevent the hospital from producing the documents on the basis that the Act permitted production "to the extent necessary" and that this would include when compelled to do so by law; and
- that public interest immunity does not permit the hospital withholding production of the records on the basis, the hospital claimed, that it was contrary to the public interest to compel production. Justice Gillard performed a balancing exercise weighing the harm to the public interest done by producing the documents as against the public interest in the proper investigation of a complaint against a medical practitioner pursuant to the Board's statutory obligations.

These unusual facts show us that doctor/patient confidentiality cannot be relied upon to refuse access by third parties in all circumstances – this is even so when both doctor and patient seek to maintain confidentiality. Moreover in states like NSW, where there is no legal privilege over the doctor/patient relationship, doctors and hospitals cannot refuse to produce records under a search warrant or subpoena simply because the patient does not consent to their production. In Victoria it is now clear that the privilege does not extend to investigation by the Medical Board. By inference, it is unlikely to apply to coronial investigations or criminal and quasi-criminal proceedings.

One can only assume the ferocity of the hospital's objections reflected a concern about the political nature of the complaint rather than a general objection to producing records to the Medical Board following a search warrant. However to protect the privacy of those concerned, the Board is still able to use a pseudonym for Mrs X.

The hospital has appealed Justice Gillard's ruling and we await the Court of Appeal's decision with interest.

Meghan Magnusson

Senior Associate - Ebsworth & Ebsworth

Kerrie Chambers

Partner - Ebsworth & Ebsworth

There is increasing demand for obesity surgery in Australia. Recently the number of procedures has been rising at a rate of 6% per month with 4,000 procedures taking place in Australia last year, double the numbers performed in 2001/02. There is evidence that incidents and claims related to obesity surgery are increasing and there is an expected further increase with the rise in the volume of surgery and the incidence of obesity in the community. In the US many medical indemnity insurers are withdrawing coverage of this type of surgery because of the rapid escalation in payouts. One Ohio surgeon dropped his obesity surgery service to avoid paying US$300,000 a year in insurance premiums[1]. While the Australian situation has not reached this stage it is clearly time to take a proactive stand in identifying and minimising risk in this area.

Obesity Surgery - Big Risk, Big Benefit?

The NHMRC has recommended that surgery be made available to selected morbidly obese patients as it has been shown to be the most effective and cost-effective treatment for this condition[2]. While it is potentially a high risk procedure on high risk patients, it has proved effective in reducing obesity related co-morbidities such as diabetes, asthma, hypertension and sleep apnoea. Surgery is performed either for treatment of these medical complications of obesity or in obese patients without intercurrent medical morbidities for more complex psychological or social reasons, in those who "don't want to be fat and unhealthy anymore". Selection criteria as recommended by the US National Institute of Health are as follows:

Body Weight

- BMI > 40 kg/m2.
- BMI 35-39.9 kg/m2 with medical co-morbidities.
- No endocrine cause of obesity.

Resistant Obesity

- Multiple failed non-surgical attempts to lose weight.
- Obesity present > 5 years.

Psychological Profile

- No alcohol or drug use.
- No (or controlled) psychiatric conditions.
- Understanding of the surgery involved and commitment to follow-up[3].

Operative mortality at < 31 days is 0.1% for gastric banding[4]. Complication rates vary from 7.4% - 10.4% most of which require abdominal re-operation. Major complications occur in less than 1% of cases and include gastroesophageal perforation, bowel perforation and gastric necrosis[5]. A range of obesity procedures are performed however laparoscopic gastric banding is the most popular in Australia.

Case Study

Ms D, a 39 year old woman presented to Dr S for surgical treatment of her obesity. She had found out about Dr S from her friend who had a laparoscopic gastric banding procedure by him 7 months previously and had since lost 16 kg. Ms D had a BMI 38 kg/m^2 but had no medical complications of obesity. She had a regular GP however she had not seen her for about a year and had not consulted her regarding weight loss options.

Ms D requested that Dr S perform the same procedure that her friend had. Dr S gave Ms D a booklet outlining the risks of gastric banding and the changes it would require in her eating patterns. The surgery was performed 3 weeks later and though the procedure went well, on Day 3 Ms D developed chest pain and fever. After investigation Ms D was managed for pneumonia and appeared to improve enough to be discharged on Day 5. On Day 10 Ms D presented to the emergency department with increasing abdominal pain and persistent fever. She was reviewed by Dr S and was returned to theatre where a gastric perforation was repaired, and the band was removed. After a protracted recovery Ms D was discharged 4 weeks after the original surgery.

Ms D was unhappy and made a complaint to the Medical Board. She felt that she had gone through a whole lot of trauma for nothing and claimed that Dr S had not informed her about other surgical options for weight reduction. She also made a claim for recovery of her $12,000 payment for the surgery as well as compensation for loss of salary and various out-of-pocket expenses.

There are many similarities between cosmetic and obesity surgery performed in those patients who do not strictly meet the aforementioned selection criteria. Although psychological morbidity may be significant in patients with a BMI between 30-40 and the carriage of this amount of excess weight is a good marker for the development of disease, the medical issues may be blurred by self referral for "lifestyle" indications. Election to proceed with surgery for these indications may see the patient as a "consumer" rather than a

patient undergoing treatment for an established medical need. The operation is likely to involve significant out-of-pocket cost to the patient with expectation therefore of outcomes that may not be realised in event of a complication. This transposes to a much higher risk of the patient making a complaint or claim against the surgeon especially if the complication leads to prolonged incapacity or disability.

Risk Management Tips for Surgeons

- Follow approved patient selection criteria for obesity surgery and in patients who fail to meet all criteria ensure discussion and awareness of the risk/benefit issues.
- Ensure the patient is fully informed of all out-of-pocket payments including anaesthetic and pathology costs. Also inform them of what the financial risks may be if a complication occurs and prolonged hospitalisation is required, particularly for those patients who are uninsured.
- If you are advertising your obesity surgery practice, ensure that you do not exploit the patient's vulnerability or lack of medical knowledge and provide only factual information.
- Have an in depth discussion of the risks of surgery and alternative treatment options. Discuss the 5-10% rate of failure of the band and an individual discussion of their peri-operative risk in relation to co-morbidities[6]. Document the discussion and provide the patient with written information about the procedure and potential complications.
- Allow the patient a cooling off period and second consultation to discuss further issues before proceeding to surgery.
- Maintain a surgical audit of outcomes and where appropriate collaborate with colleagues to discuss any problems or risks to patient safety.

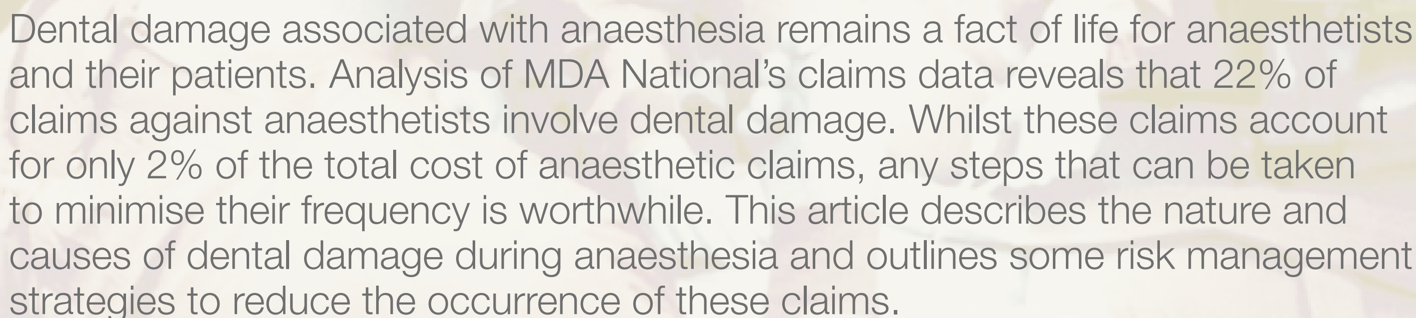
Risk Management Tips for GPs

- Discuss different surgical and non-surgical options prior to referral for surgery.
- Consider using an established guideline for management of obese patients such as the U.S. National Health, Lung and Blood Institute Guidelines[3].
- Wherever possible consider referral to a surgeon with experience in a reasonable number of obesity procedures. Surgeons learning the procedure or who do the occasional case (< 10 per year) may not have the critical volume to develop experience in managing complications especially if their usual surgical field of interest does not involve oesophago-gastric surgery.
- Be wary of referring patients to surgeons who operate in hospitals geographically distant from their usual practice and who leave patients without adequate post-op support or an appropriately trained delegate to supervise the patients' ongoing management.

Louise Kershaw
Risk Manager

Dr Michael Talbot
FRACS

1. *PIAA Newsbriefs* June 15, 2005
2. MSAC Assessment report (2003) *Laprascopic Gastric Banding for Morbid Obesity*
3. US National Health, Lung, and Blood Institute. *Clinical guidelines on the identification, evaluation, and treatment of obesity in adults* http://www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm
4. Buchwald H et al (2004) *Bariatric Surgery. A systematic review and meta-analysis.* JAMA 292, 14: 1724-1737
5. Ceelen W (2003) *Surgical Treatment of Severe Obesity With a Low-Pressure Adjustable Gastric Band - Experimental Data and Clinical Results in 625 Patients* Ann Surg Vol. 237, No. 1, 10–16
6. Ren CJ et al (2005) *Factors effecting patient choice for bariatric operation.* Obesity Surgery 15, 2: 202-206



Dental damage associated with anaesthesia remains a fact of life for anaesthetists and their patients. Analysis of MDA National's claims data reveals that 22% of claims against anaesthetists involve dental damage. Whilst these claims account for only 2% of the total cost of anaesthetic claims, any steps that can be taken to minimise their frequency is worthwhile. This article describes the nature and causes of dental damage during anaesthesia and outlines some risk management strategies to reduce the occurrence of these claims.

Dental Injury During Anaesthesia:

Anaesthesia-related dental injury occurs in many different guises. Consider the following (unusual) incidents recently reported to MDA National:

Case 1

The anaesthetist was performing an epidural for an urgent caesarean section. His usual practice was to perform epidurals with the patient lying on the left side. The patient was having trouble maintaining the required posture, not helped by her marked anxiety, so the anaesthetist decided to sit the patient up to perform the block. The patient's husband was attempting to calm his wife. However, when the husband stood up in front of his wife to assist, he caught sight of the epidural needle, just as the anaesthetist was inserting it. He fainted and hit his head on a bench as he fell, sustaining a superficial abrasion to his forehead and chipping an upper front incisor tooth. The anaesthetic aide immediately pressed the emergency button for assistance. The husband was placed on a trolley while the anaesthetist proceeded to complete the block. By the time the caesarean was finished the husband had completely recovered. He declined further offers of assistance and happily departed to the nursery with his newborn child.

Case 2

The elderly patient was undergoing an emergency laparotomy. As the anaesthetist approached the patient, she tripped over the wheels at the head of the bed. As she fell, the blade of the laryngoscope made contact with the patient's mouth and dislodged both of the upper central incisors.

Neither incident has proceeded to litigation.

Discussion

The incidence of anaesthesia-related dental injury has been estimated to be 0.02%[1]. It has been reported that 50% of the injuries occur during laryngoscopy and tracheal intubation. Another 23% were recognised as occurring during the case but after tracheal intubation. Only 8% of the incidents were noted to occur during tracheal extubation. For the remaining 19% of cases, an exact time of injury was not determined. The upper central incisors are the most commonly involved teeth. Most injuries are crown fractures and partial dislocations and dislodgements. Generally only one tooth is damaged but simultaneous trauma to more than one tooth has been reported in up to 13% of cases. Dental damage is five times more likely to occur when there is a pre-existing dental condition but sound teeth are also at risk [2]. The other significant risk factor for dental injury is increased difficulty of laryngoscopy and oral intubation.

Is Dental Injury During Anaesthesia Negligent?

There are three elements that must be established in order to satisfy negligence. First, the patient must prove that the medical practitioner owed them a duty of care; second, that there was a breach of that duty of care; and third that the negligent act caused the patient damage or injury. Dental injury during properly conducted anaesthesia is not, by definition, negligent. When determining whether or not a matter should be settled, MDA National will consider the circumstances of the particular case and the preferences of the member. Assessment of the case includes the member's pre-operative evaluation of the patient and whether or not the dental damage occurred as a result of the anaesthetist's actions. There are cases where the dental damage may not be related to the anaesthetic, especially where there is a delay between the procedure and the occurrence of the damage.

Is It Negligent?

Similarly, situations where a patient has poor dentition and is warned of the risk of dental damage may not involve negligence. One memorable case involved an anaesthetist who reported dislodgement of a crown in an elderly patient. Pre-operatively the anaesthetist had carefully examined the patient's mouth and warned him of the possibility of damage to the crown which was already loose. Post-operatively, the patient asked our member who was going to pay for his dental treatment. Not unreasonably, the anaesthetist was adamant that he was not responsible for the repair of the dental damage that had occurred during a carefully performed anaesthetic. After discussion with MDA National, it was agreed that the anaesthetist would advise the patient that, whilst he was sorry that the crown had been dislodged, the patient would have to foot the bill for the dental treatment. The anaesthetist subsequently sent a written incident notification to MDA National outlining the incident and the patient's response. Fortunately no claim ensued, despite the patient's initial dissatisfaction with our member's approach.

Risk Management

The following risk management strategies will minimise the likelihood of your involvement in a claim arising out of anaesthesia-related dental damage:

- Take a dental history and perform an oral examination before general anaesthesia.
- Discuss the possibility of dental damage with patients, especially when there are pre-existing dental problems.
- Document your pre-operative discussion and assessment in the medical records. Significant findings should be noted.
- Record the type of airway management and indicate if no oral instrumentation was employed.
- Take care with the technique of intubation and the use of oropharyngeal suckers.
- Check for dental damage after intubation, extubation and recovery. Document relevant findings.
- Ensure recovery staff are aware of the potential hazards of forceful removal of oropharyngeal airways and laryngeal masks when the teeth are clenched.
- If dental damage has occurred, locate the tooth or fragment as soon as safely possible and institute immediate emergency management of the dental trauma.
- Explain to the patient how the damage occurred, without self blame, and describe any efforts that were made to avoid the injury.
- Do not introduce the subject of costs or offer to pay for the dental treatment.
- In some circumstances, consider reducing or waiving the anaesthetic fee.

As always, members are encouraged to seek early advice and assistance from MDA National with any incident.

Dr Sara Bird

Medico-Legal Claims Manager

1. Warner ME, Benenfeld SM, Warner MA et al. *Perianesthetic Dental Injuries: Frequency, Outcomes, and Risk Factors*. Anesthesiology 1999; 90:1302-5.
2. Owen H, Waddell-Smith I. *Dental Trauma Associated with Anaesthesia.* Anaesthesia and Intensive Care 2000; 28:133-145.

Student Elective Essay Competition

The MDA National Elective Essay Competition is held every year to assist student members of MDA National with funding for their elective program.

Students are asked to write a short essay on the following topic:

"The elective term is a central part of the medical degree in Australia. With regards to your chosen location, discuss how the medical elective adds value".

This year saw over 70 entries for the competition, with essays covering almost every continent. Some students have elected to complete part of their elective in Australia, in places such as Alice Springs, while overseas locations were as far-reaching as Taiwan and the Solomon Islands, to Sri Lanka, India and Cambodia.

Entries were judged this year by Council members Dr Tom Hugh and Dr John Blackwell and MDA National staff, Dr Sara Bird and Penny Johnston.

This year's first prize of $2,000 was awarded to Robert Granger from the University of Tasmania.

First runner up, with a prize of $1,000, was Monika Skubisz from the University of Melbourne and Second runner up, with a prize of $500, was Shiv Anand Hemum Seegobin from Monash University.

Congratulations to the winners!

First Place: **Robert H Granger - University of Tasmania**
Location of elective: Lesotho, South Africa

Professor Fred Hollows, widely recognised for restoring vision to the disadvantaged populations in Australia and abroad, was also renowned for his deep insight into human behaviour. One of his popular lines was, "You disappoint yourself more often by not doing things because of cowardice and temerity than you ever did by doing things that turn out to be wrong." My life's experiences have often attested to the truthfulness of this statement and the elective period will be the perfect opportunity to demonstrate its antithesis.

I have chosen to fulfil my elective in a 160-bed mission hospital in Lesotho (pronounced Le-soo-too). About half the land size of Tasmania, the mountainous Kingdom of Lesotho is landlocked by South Africa. Maluti Hospital's six doctors serve a catchment area of about 100,000 persons in a country of around 2,000,000. While the altitude places its inhabitants out of reach of the anopheles mosquito, it affords no protection against the ravages of tuberculosis and HIV, the latter affecting up to 80 per cent of the hospital's patients. Courage over cowardice is valued by Maluti's staff.

Most admissions fall into three broad categories: infectious, obstetric and trauma. There is very little to separate paediatrics, geriatrics, obstetrics, emergency, intensive care, surgery, pulmonary, cardiology and every other '-ic' and '-ology' in the hospital. Doctors care for the patients they admit, regardless of their age, gender or presentations. I will be attached to the wards as well as working with their ophthalmologist. I'll be expected to take histories, conduct physical examinations, order tests, make diagnoses and management plans, prescribe, admit, book operations and discharge patients. Maluti values confidence over timidity.

There will be plenty of procedures happening if I am prepared to do them, including placing cannulas, chest drains and urinary catheters; performing spinal taps; taking blood; aspirating joints; suturing wounds; assisting with surgery and much more. The doctors have said, "Welcome to a procedure-learning haven." I understand that the patients are extremely tolerant when mistakes are made, though Maluti nonetheless values carefulness over rash boldness.

I have been advised that medical students undertaking electives at Maluti Hospital must not expect to be spoon-fed. I will often not have anyone watching what I do and when I do it. I could be there for six weeks and do almost nothing, or nearly everything - depending on how involved I choose to become. As a medical student I could take days off without anyone noticing, because it's my role to take the initiative. I am sure that Maluti values conscientiousness over idleness.

I suspect that the experiences acquired during the elective are intended to do more than make me a better final-year student, as the practice of medicine is more about the patient than it is about me - the doctor. And strengthening the qualities of courage, confidence, carefulness and conscientiousness is one step in that direction. With such value-adding, I'm sure that Prof Hollows would have affirmed my choice to do an elective in Maluti as the right choice.

First Runner Up: **Monika Skubisz - University of Melbourne**
Location of Elective: India

Consider the humble stethoscope. Invented in 1816 by Rene Laennec and to this day swinging casually around the necks of doctors worldwide, this essentially rudimentary instrument revolutionised medicine by allowing doctors to 'see' the body as they have never seen it before; polyphonic wheezes and crackles, murmurs and borborygmi - an entire previously unseen world was suddenly revealed to wide-eyed physicians, to be mapped, named and conquered, to assist in diagnosing and ultimately helping patients with a whole new level of understanding. It remains a fundamental part of our practice today and may even be regarded as a symbol of our profession.

Now consider a medical elective in India: a cacophony of sounds, a noisy collage of visuals, a multitude of smells, rancour and sweet, to heave at and waft away all at the same time. Some would say a sensory overload. And amongst all this, a myriad of people so populous and varied with an amalgamated need so huge, the mere imagination of which makes any health budget want to buckle and run away in terror. But what do a stethoscope and a medical elective have in common to the informed practice of medicine?

- Perspective
- Insight
- Imagination

Medicine is undoubtedly the science of people and as any self-respecting medical curriculum will have you know, a person comprises not only of a physical body to be understood through instruments and diagnostic test, but it is also a complex entity of emotions, experiences and a subjective, lived experience. We, as empathetic, 'wholistic' doctors of the future, are expected to have an intimate understanding of these detailed facets of our patients, yet the very nature of the medical degree and the demands of the profession - endless study, long-haul shifts and a manic pace - leave precious little time to go about the business of actually getting to know people. To live and reflect on their desires, conceptualisations and circumstances, to understand what makes them tick (other than their (physical) hearts).

To travel is to lead another life. To leave behind what is known and familiar to us and to come to know other paths and people. So in decreeing the medical elective an integral part of the medical degree, I believe we are hoping to add to our sensory knowledge of patients, so that just as we listen to, visualise and understand the physical as relayed to us by our stethescopes, we can listen to, visualise and understand the non-physical signs, symptoms and realities of our patients. To endeavour upon that final frontier, to know another human being.

Second Runner Up: **Shiv Anand Hemun Seegobin - Monash University**
Location of elective: Mauritius

I chose to do my elective in Mauritius, an island country tiny enough to fit into Melbourne's Port Phillip Bay. It is on the Tropic of Capricorn, 600 kilometres off the East coast of Madagascar in the Indian Ocean. Its one million inhabitants have the pleasure of a landscape which convinced Mark Twain that "God created Mauritius first then copied paradise from it", but my own reasons for choosing Mauritius for my elective are somewhat different...

There is a typical Mauritian joke that goes: An American, French and a Mauritian man meet to decide what the fastest thing in the universe is. American: "Light definitely. Travels at 300 million metres a second." French: "Thought is faster than light. Light takes millions of years to reach the next star in the galaxy, but a thought can make you see the other side of the universe in less than a second." Mauritian: "No way, diarrhoea is faster than light or thought. Last week I had diarrhoea in the middle of the night, I woke up, there was no time to switch the light on, I couldn't even think, and ..."

This joke sums up how I conceive Mauritius: an island with a candour characteristic of its geographical isolation and economic poverty, but by the same token, dotted with a profound sense of humility. The population is a penta-lingual mixture of Indian, African, Chinese and French. Exotic? Perhaps, but not quite paradisiac.

The average Mauritian earns under 250 Australian dollars monthly. The country has one third the doctor-per-people ratio of developed nations. Often neither the human nor the logistic resources are available to offer good and timely healthcare to who is lucky enough to make it into one of the few hospitals. For example, the island, which has only one, 5-year-old medical school, has no Paediatric Surgeon, no Otologist, no Plastic Surgeon, no Endocrinologist, no Neurosurgeon, and no IVF facility. It has only two CT scanners, and only recently opened a Neonatal ICU, that can only care for seven lucky babies at a time. In a typical ward in a public hospital there are 50 patients in a hall, sharing one TV set, with computers rarer in the hospital than TV sets.

Cleft palates, hypospadia, burns, wounds requiring plastic reconstructive surgery, are bravely managed by General Surgeons. For me, such a healthcare ecology constitutes an opportunity for invaluable medical learning. By doing a general surgical elective in this microcosm, I will observe healthcare, and health, in all their dimensions: how socioeconomic dynamics of a community impact on the care needed by a patient and on the care received by the patient; how different cultural influences and low education impact on the perception of illness; how fundamental principles of surgery can be applied to improvise in the absence of formal specialist training; how the clinical diagnostic process and management strategy adapts itself to a lack of supportive technologies that is often relied on elsewhere. I hence look forward to this experience of considerable value to my medical education.

The Electives Network

Planning an elective can be an exciting time, but it can also be overwhelming. With so many places to go, how do you decide which elective placement would best suit your personality, interests and career aspirations?

The Electives Network (TEN) was founded in the UK in 2001 by then medical student Gordon Hamilton. It has been designed to help medical students plan their elective by providing up to date and comprehensive information. TEN is an invaluable web-based resource that enables medical students to research elective opportunities around the world.

In Australia it is available only to student members of MDA National.

TEN aims to help you every step of the way, with a comprehensive database of over 4,000 hospitals, more than 100 country profiles, visa and travel information and a range of hints to ensure your elective happens like clockwork!

TEN Includes:

Where to go – search the database of over 100 country profiles to find exciting destinations and pick suitable hospitals to apply to from over 4,000 listed on the site.

Planning – advice on everything from funding to flights, vaccinations to visas.

Forums and feedback – every year TEN collects and collates hundreds of feedback forms from students who have returned from their electives. Find out their thoughts on where to go and what to do.

How to log-in

- Go to www.mdanational.com.au
- Click on the yellow box on the home page, or go to the student section on the website
- Go to "Access The Electives Network here" button
- Enter your user name – your surname
- Enter your password – your member number
- And you're in!

Forgotten your password? Call our friendly Client Services Team on 1800 034 466 (WA) or 1800 011 255 (all other states) and they will be able to help you.

Electives with a Difference

Looking for an elective with a difference?

Fancy spending some time of your elective time behind bars? There is information on the UK Prison System where you can do a 2-3 week placement in a very different setting.

If that doesn't take your fancy what about volunteering in Nepal, or spending time flying with the Royal Flying Doctor Service a little closer to home.

Spend time in a busy trauma hospital in the UK, or see the country with a rural term in far north Queensland.

TEN has information on all these electives with a difference, plus many more.

Feedback and Competitions

You can win prizes by telling TEN about your elective. Each quarter MDA National and TEN are giving away prizes – all you have to do is tell us about your experiences!

When you return from your elective, go to www.electives.net/feedback, fill out a feedback form and go into the draw to win a mini Apple i-pod.

MDA National

Notification of Incident Form

1. Member Details

Member Name:

Member Number:

2. Patient Details

Name:

Address:

Employment:

Date of Birth: Gender: Male ☐ Female ☐

Treatment Given:

Outcome:

Patient type: Private ☐ Public ☐

3. Other Practitioners Involved

Name: Address:

Name: Address:

Name: Address:

4. Incident Details

Location of incident:

Date of incident: Date you became aware of incident:

Your medical speciality at time of incident:

Brief summary of incident

Include details of patient presentation, diagnosis, treatment and outcome.

Do not send originals of medical records – send copies only if relevant to the notification. Please ensure your original records are preserved and kept separate from any correspondence with MDA National Insurance. If this matter develops into a claim, they will become critical to your defence.

Attach any correspondence relevant to the notification. Attach additional comments on separate pages if necessary.

Signature: ______________________ Date: ______________________

Policy holders based in WA, NT, SA and overseas

Please post or fax the completed form and related documents to:

Claims Division, MDA National Insurance
PO Box 1557, Subiaco WA 6872
Fax: (08) 9415 1492

Policy holders based in all other states

Please post or fax the completed form and related documents to:

Claims Division, MDA National Insurance
Level 5, 69 Christie St, St Leonards NSW 2065
Fax: (02) 9460 8344

Perth
Level 3
516 Hay Street
Subiaco WA 6008
Ph: (08) 6461 3400
Fax: (08) 9415 1492

Melbourne
Level 1
101 Dundas Place
Albert Park VIC 3206
Ph: (03) 9915 1700
Fax: (03) 9690 6272

Sydney
Level 5, AMA House,
69 Christie Street
St Leonards NSW 2065
Ph: (02) 9023 3300
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Form 112.2

Please notify us now...

Do not forget to let us know, as quickly as possible, of any incidents that may give rise to a claim. In some cases a claim can be minimised or even avoided altogether where we have immediate notification.

It is also a condition of your MDA National Insurance Professional Indemnity Insurance Policy that claims or circumstances are notified in writing as soon as practicable.

Don't wait for a complaint or adverse outcome to become a claim before you notify us of the incident concerned. It is a good rule of thumb that if you are worried about an outcome, you should report it.

In order to assist you with this process, MDA National Insurance has developed this Incident Notification Form. A copy is also available on our website www.mdanational.com.au

Remember – the sooner we know about an incident, the quicker we can help.

Annual General Meeting 2005

- Preliminary notice to members

Members with voting rights should note that the 79th AGM of the Medical Defence Association of Western Australia (MDA WA trading as MDA National) will be held on Wednesday 23 November 2005 commencing at 5.45pm at Level 3, 516 Hay Street, Subiaco WA.

In accordance with Rule 20.2 of the Association, the following Members of Council retire:-

Dr Fiona Bettenay

Dr Tom Hugh

Dr David Watson

Dr Bettenay, Dr Hugh and Dr Watson being eligible, offer themselves for re-election.

Dr Robyn Napier was appointed to Council pursuant to rule 20.8 of the Association to fill a vacancy and in accordance with that rule retires and being eligible, Dr Napier offers herself for election to Council.

In accordance with Rule 20.4 of the Association, nominations for election to Council are invited and must be received in writing by the Chief Executive Officer at the office of MDA National by 5.45pm on Wednesday 26 October 2005. Nominations must be signed by the nominee and the member proposing that person for election. The nominee should include some information on their background and experience which may be used by the Association for the purpose of the election.

Members wishing to serve on Council as well as representing the interests of members should ideally have or be prepared to build a working knowledge and understanding of business and governance requirements. Medical defence organisations are becoming more regulated and in future Council members may be required to meet a number of specific requirements to continue to serve as Councillors.

Further information is available by contacting the office of the CEO.

A formal Notice of the AGM detailing all agenda items will be circulated with the Annual Report and proxy forms fourteen (14) days prior to the meeting.

Defence Update via email

Would you like to receive *Defence Update* by email?

We offer all readers the opportunity to receive an electronic copy of *Defence Update* instead of a hard copy.

If you would prefer to receive your quarterly magazine by email, please let us know by sending an email to **defenceupdate@mdanational.com.au** putting the word 'Subscribe' in the subject line and including your name and member number in the body of the email.

You will be able to change the way you receive *Defence Update* at any time, simply by sending an email to the address above.

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